Pop News

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Message from the Scientific Director

Population and Public Health in Canada: Failed Promises but Potential for Change

(Feature article, based on a summary of the presentation by Scientific Director, Dr. John W. Frank, at the 2004 Health Canada Science Forum in Ottawa.)

The health goals of the nation are implicitly tied to the cultural and national values Canadians share, values that imply a promise of fairness in the distribution of health benefits: All citizens have the right to enjoy good health and the right to equal access to effective care and proven preventive strategies for maintaining health. Under this rubric of fairness, the wide variations in health status that exist within Canadian society merit careful examination. What do these disparities reveal about our approach to public health? How well do we understand the incidence rates of ill health and premature death along the socioeconomic gradient in health?

In Canada today, socioeconomic disparities are arguably the most predominant factors influencing the majority of health outcomes. As such, they provide a unique perspective on the determinants of health, particularly from the standpoint of traditional public health. There is a growing recognition among industrialized countries that the movement toward establishing national health goals must be accompanied by effective strategies to address health disparities – a responsibility the governments of all developed nations are starting to take very seriously.

Research is revealing more and more about the urgent need to reduce health disparities. A Statistics Canada study, which examined the relationship between earnings and reported deaths among Canadian males enrolled in the Canada Pension Plan during the first five years following mandatory retirement, points to the fractal nature of socioeconomic gradients in health outcomes. Researchers found that as the average earnings of males increased over the twenty years prior to age 65, mortality rates in the 65 to 70 age bracket had a stepwise tendency to decrease*.

The study's findings are statistically robust for the data show quite dramatically that workers in the bottom decile face double the risk of death in the first five years following retirement compared to those in the very top decile. How researchers interpret these patterns and understand their origins, for example in the socially inequitable distribution of common risk factors for chronic disease, will likely set the course for future public health efforts to reduce such disparities.

Reflecting on theories of Sir Geoffrey Rose[1], one of Britain's most respected epidemiologists, it is worth noting that whenever there is a risk factor present, unless the actual shape of the dose-response curve is fully understood, it is difficult to know whether one should target the smaller, high-risk population or the larger group in the middle (people categorized as normal) where most of the attributable risk resides. This dose-response curve is a critical input to economic and social policies aimed at children living in poverty, and must be taken into account each time Treasury Board formulates amendments to tax and transfer policies – decisions which have a direct impact on the number of children who remain poor and on the health status and coping abilities of these same children over the life course. Rates of child poverty in Canada, after taxes and transfer payments, are exceeded only by those in the US, which means that in comparison with other OECD[2] nations, Canada is not faring terribly well. It is therefore important that public health experts continue to bring to the attention of decision-makers the distributive consequences of tax policy and their anticipated outcomes in terms of population health.

The effect socioeconomic status has on an individual's health and longevity should not be underestimated. Even the decline in mortality rates over the last 40 to 50 years – generally regarded as a Canadian success story – cannot be attributed solely to improvements in diet, reductions in tobacco use or the medical management of cholesterol, body weight or hypertension. Inequalities in health persist. A groundbreaking Statistics Canada study using local census tract mean income figures illustrates the gap between the lowest income quintile and the

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Scientific Director's Message (cont'd)

top income quintile in the incidence of ischemic heart disease (IHD) in males over a twenty-year period, from 1976 to 1996[§]. While analysts observed a narrowing of this gap in the 1980s, they could find no discernable improvement over the remaining years leading to 1996.

This finding raises a number of important questions. Does the gap occur because IHD risk factors, such as smoking, are known to be increasingly concentrated in the lower socioeconomic groups? Or are lower-income people simply not getting to the hospital quickly enough with chest pain? Is access to the best treatments, once they get there, an issue? Our understanding of which of these factors underlies the "pre-existing inequality" in Canadian IHD mortality could be improved greatly by accurately ascertaining the sum of sudden deaths in the community and confirmed heart attacks admitted to hospital, which is an inexpensive surveillance activity not currently undertaken in Canada.

The obesity epidemic is another issue which can be viewed through the prism of fairness. One cannot ignore the immense cultural shifts occurring across all strata of North American society. Poor eating habits and lack of exercise are having a negative impact on large segments of the population, pushing the Body Mass Index (BMI) distribution to the right with tidal-wave force. Economics also plays a role. For example, the rapid rise in US corn production (which nearly doubled in the past twenty years) may be closely linked to trends in the fast food industry, such as increased portion sizes and a higher utilization of government subsidized corn products (including meat raised on cheap corn as feed)"*. The reasons for poor health can often be found far upstream, firmly anchored in culture, economics and public policy.

In conclusion, policy makers are urged to move beyond traditional definitions of public health to more upstream thinking about the determinants of health. Seeking out the root causes of disease and disability, considering and dealing with whole populations, and understanding and applying the principles of social change over the life course are the key principles we need to adhere to as we enter a new era of public health in Canada.

Warm regards,

John Frank
Scientific Director

Endnotes to the Scientific Director's Message

* Wolfson M, Rowe G, Gentleman JF, Tomiak M. Career earnings and death, a longitudinal analysis of older Canadian men. *J Gerontol 1993; 48(suppl):167-179.*

† Rose G. Sick Individuals and sick populations. 1985; *Int J Epid* 12:32-38.

‡ Organization for Economic Co-operation and Development.

§ Statistics Canada, Catalogue 82-003. Supplement to Health Reports, volume 13, 2002, p. 57.

** (The (agri)cultural contradictions of obesity; Michael Pollan, New York Times Magazine; October 12, 2003; research library; pg. 41.

The Canadian Coalition for Global Health Research—An Update

Vic Neufeld MD, National Coordinator, CCGHR

"How can Canada increase its investment and involvement in research targeted on the health problems of societies in low and middle income countries?" Four years ago, this question started a "movement" in Canada that has evolved along two tracks. One involves Canada's federal agencies concerned with health research, where four agencies signed a memorandum of understanding to form the Global Health Research Initiative (GHRI). Dr. John Frank, representing the CIHR, is a key leader in this initiative.

Complementing the GHRI is a not-for profit organization--the Canadian Coalition for Global Health Research (CCGHR). Its vision is:

- To promote better and more equitable health worldwide by:
  - Mobilizing greater Canadian investment in global health research;
  - Nurturing productive research partnerships among Canadians and people in low and middle-income countries;
  - Translating research into action

Launched in 2003, the CCGHR now has a board of directors, several task groups, a secretariat (shared with the GHRI), a website, and an active membership of more than 400 individuals, many of whom live and work in low and middle-income countries (LMIC). Summarized below is one activity that illustrates what we do.

In July 2004, the Coalition launched its first "Summer Institute for new Global Health Researchers"—a 5-day workshop held in Halifax, hosted by Dalhousie University. This institute reflects part of the Coalition's mission to "nurture the next generation of global health researchers in Canada and LMICs". Twenty-one "new" researchers worked with a team of facilitators, focusing on the challenge of getting research translated into policy, practice and action. The participants worked in "dyads" where a Canadian and someone from a LMIC worked together on the same project. The event was a great success, and a second Institute will be held in Tanzania in July 2005.

For further information, check out our website: http://www.ccghr.ca

Changing the open competitions funding formula: from 80:20 to 100:0

Submitted by Morris Barer, Scientific Director, CIHR Institute of Health Services and Policy Research

In November 2002, Warren Thorngate and colleagues from the psychology department at Carleton University delivered a report to CIHR that analyzed the outcomes of CIHR's open competitions (see *Mining the Archives: Analyses of CIHR research grant adjudications* at http://http-server.carleton.ca/~warrent/reports/mining_the_archives.pdf). This analysis revealed that medical research committees (largely pillar 1) weighted evaluation criteria quite differently than health research committees (largely pillars 3 and 4), with the former putting more emphasis on experience and track record, and the latter on methods and analytic plans. The research team also found that, overall, there tended to be more disagreement among members of health research committees, and that disagreement was associated with lower ratings. As a result, both committee and private ratings on health research committees tended to be considerably lower than those emerging from medical research committees.

This was an important set of findings, because CIHR was using an "80:20" rule for allocating funds across committees—80% of the funds would be awarded on the basis of universal percentile cut-offs (e.g. if the funding available for the competition could support an overall success rate of 30%, the top 24% of applications reviewed by each committee would be funded, assuming they were rated as "fundable"), but the remaining 20% of the funds would be allocated on the basis of a pooled ranking of all applications in the competition. With health research committees generally rating applications lower than medical research committees, few health research grants were funded from the pooled ranking list, and overall success rates for these applications were accordingly lower.

To address the issues raised in the Thorngate report, as well as other concerns that had emerged in the early days of CIHR, the organization established an ad hoc group, the FAIRR (Fairness in Ratings and Rankings) committee, subsequently replaced by the permanent Sub-committee on Monitoring and Innovation in Peer Review (SMIPR), a sub-committee of the Standing Committee for Oversight of Grants and Awards Competitions (SCOGAC). These two committees have been working diligently over the past couple of years to undertake additional analyses and consultations.

Recently SMIPR presented a proposal to SCOGAC—which it endorsed and in turn presented to CIHR's Governing Council—to replace the 80:20 allocation formula with a straight 100:0 formula (e.g. if the available funding can support an overall success rate of 30%, the top 30% of applications to each committee will be funded). This means that there will be the same success rate in all peer review committees, so long as all grants above the funded percentile (e.g. about 25% in the last competition) receive a rating of 3.5 or higher. This proposal was supported by the Governing Council at its last meeting, and for an initial period of five years, beginning with the March 2005 competition, funds committed to open grants and awards competitions will be allocated on the basis of 100:0. This approach will be evaluated toward the end of that five-year period.

While SMIPR continues to have a full agenda in its constant quest to improve peer review, this decision represents an important milestone in the life of CIHR.

The Canadian Public Health Association – Into the Future

Dr. Elinor Wilson, Chief Executive Officer

"The trouble with the future is that it usually arrives before we're ready for it". (Arnold H. Glasgow)

The public health community across Canada and around the world would have no trouble agreeing with that statement. Whether it's new epidemics of chronic disease, environmental degradation and change, the perils of untested new technologies, or the permeability of provincial/territorial, national or international borders, the future is here.

The Canadian Public Health Association was constituted in 1908 by an Act of Parliament, to focus on a pan-Canadian approach to the public health issues of the day. CPHA continues today working toward a better public health future. We're building on our strengths of partnership, facilitation, long-established legitimacy, and policy development while we review our Board structure, our current priorities, our professional journal, and our enhanced role in communications and knowledge transfer and exchange.

This cannot be accomplished without partnerships. Our memorandum of understanding with CIHR's Institute of Population and Public Health, the Public Health Agency of Canada, and The Canadian Population Health Initiative, a part of the Canadian Institute for Health Information strengthens all aspects of our work, whether in our national conference, our national and global programs, and our policy development.

Internally, CPHA's Board of Directors has taken steps to better position CPHA to continue to play a leadership role in the changing public health environment, with the following priorities:

- **To determine a Pan-Canadian Public Health Agenda**
- **To focus on the development of public health human resources**
- **To increase CPHA's core capacity by developing a long-term financial plan**
- **To re-energize CPHA's membership**
- **To develop a proactive, innovative and sensitive organization culture.**

We look forward to continuing our collaborative work in this Brave New World, and invite you to join us in our endeavours.
http://www.cpha.ca

Véronic Ouellette, PhD Student, Health Care and Epidemiology, University of British Columbia, and Student Representative, Board of The Canadian Coalition for Global Health Research

During medical school, I had the privilege of collaborating with health and environmental NGO's across Latin America. I was immersed in the joy and suffering of people without access to health care and living on very small incomes. I felt enriched by my encounters with people who have built health centers and transportation systems at great personal costs. Nevertheless, I felt puzzled. Are the interventions currently carried out yielding the expected results? How could I most effectively address some of these overwhelming challenges? Raising awareness of other students and being involved in small projects was not enough. I engaged in a path of research and capacity building initiatives for the new generation of researchers, which I hope, will be supported by all members of the Canadian research community.

It led me to do a Masters degree in Health Administration. I tried to do it on global health issues but opportunities (research supervisors and funding) were unavailable at the time. My thesis on access to care following a reform showed the important discrepancies arising from changes in perceived access while there was no change in reported waiting times. It provided an insight to decision makers as to how the perception of what was acceptable was driving a social movement.

My commitment to evidence-based policy, plus the lack of research to answer many relevant questions, combined with the desire to carry valid research in global health prompted me to start a program combining a PhD and a Residency in the specialty of Community Medicine. Through this joint program I became involved with the Centre for International Health at UBC. I am currently part of a project funded under the Global Health Research Initiative (GHRI) investigating Cuba's experience in managing health determinants in order to draw lessons for other developed and developing countries (after all, Cuba obtained the health status of a developed country while having a GDP of a LMIC.) Our preliminary results indicate that the intersectoral management of health determinants linked with a comprehensive surveillance and impact monitoring system is key to this achievement.

Through this project I participated in the First Summer Institute for New Global Health Researchers of the Canadian Coalition for Global Health Research (CCGHR). This summer Institute is one of the greatest accomplishments of the capacity building committee of CCGHR, which is now focusing on enabling leaders in global health research to foster a new generation of global health researchers. The summer institute provided a wonderful opportunity to learn and reflect on knowledge translation issues and how to organize our research to have relevant global impact. During the Institute, a group of young researchers from Canada and LMIC's held a session on the challenges of developing careers in global health. A sub group consisting of Valery Riddle (Laval University), Susan Walker (McMaster University) and I pursued the reflection further and wrote a commentary article which will hopefully be accepted as part of a special edition of the Canadian Journal of Public Health on global health.

In summary, while we were excited about the Canadian potential to contribute to global health research which is newly supported by GHRI, and while students represent an untapped potential to contribute to the creation of new knowledge in global health, we concluded that many difficulties remain. The challenges include the short time frame of research funding, the difficulties of establishing and maintaining meaningful collaboration, as well as the lack of dedicated time to disseminate results to the local communities in a relevant and ethical way rather than only communicating them to the scientific community through journal articles. The nature of global health research is complex, and to be researched properly many global health problems need interdisciplinary collaboration. The funding and reward structures currently in place in universities do not value this. The sharing of our experiences help us gain insight into what is paramount for new researchers to enable them to significantly contribute to global health : the commitment of universities, Deans and funding institutions to promote and adequately support this field.

On another line, with SUNSIH* and CCGHR, we have sought to develop a program in response to the needs of SUNSIH members, university-based global health organizations, who are interested in active research involvement and opportunities for undergraduate training as a way of increasing the positive impact of their projects. If you are interested in becoming a research mentor, or to facilitate this initiative, do not hesitate to contact me at cieltrotteur@hotmail.com .

My PhD projects will link all my interests and involvement: I hope to establish a strong mutually beneficial collaboration with the Tanzanian Essential Health Intervention Project (TEHIP) to assess the impact on economic development of interventions to improve health. TEHIP is a project funded by IDRC, which has significantly decreased mortality and morbidity in pilot regions of Tanzania. It will serve as a case study for the CCGHR Second Summer Institute for New Global Health Researchers in Tanzania this summer. I have the pleasure to be chairing the planning committee for this Summer Institute.

Finally, I want to thank all the organizations named in this profile, which have demonstrated support for the new generation of global health researchers and I hope many more will join in this journey which has the potential to not only improve the health of LMIC citizens but bring insight on how to improve in cost-effective ways our own health system and better serve our own marginalized populations.

* SUNSIH is the Student University Network for Social and International Health.

Teams, Emerging Teams and Research Resources – New Standing CIHR Competitions

During the past four years, CIHR's portfolio of funding programs has grown considerably. While the causes—increased funding, the broader mandate of CIHR, and the need to foster greater collaboration across disciplines, between institutions and with the community—may be celebrated, the research community has told us that it is difficult to keep pace with the frequent and unpredictable array of funding opportunities.

Over the next five years, CIHR intends to simplify its portfolio by combining funding programs with similar objectives. Building on the idea of bi-annual "program launches", CIHR will adopt a regular cycle for announcing *all* funding competitions. Most competitions will have an open component, which will accept applications in any area of health research, and a priority announcement (or strategic) component, which will encourage applicants to direct their efforts towards priority research areas identified by the Institutes. The goal is a simple, well-designed portfolio of funding programs flexible enough to accommodate all approaches to health research.

The first step in this simplification process is the consolidation of programs designed to support research teams. The CIHR Team Grant competition, which was first launched in September 2004, will be one of three new regular programs: the others will be the Research Resource Grants (which will include support for the development of theories, frameworks, research methods, measurement tools, and evaluation techniques), and the Emerging Team Grants (which is intended to consolidate a number of existing funding tools, including the ICE tool). The second round of the CIHR Team Grant competition will be launched in June 2005.

With the introduction of the CIHR Team Grant program, it is the intent of CIHR to fund a variety of expert teams (unidisciplinary teams, multidisciplinary teams, transdisciplinary teams, community-partnered teams, academic-industry teams, etc.). The unifying element underlying all successful CIHR Teams will be a commitment to excellence and the pursuit of a problem-based, collaborative approach to health research. Team Grants will be funded for a maximum of five years, and are renewable through regular competitions.

We recognize that changes to our programs have to be managed carefully in order to avoid disruption to continuing research, and that we must engage researchers and their partners in improving the ways in which we support health research. We are now in the design phase for the Research Resource Grant and Emerging Team Grant programs, and will continue to look for input from the research community and our partners as we consolidate our team-oriented funding programs.

Mapping the Future of Public Health: People, Places and Policies

The Canadian Public Health Association's 96th Annual Conference,

September 18 - 21, 2005

Register on the CPHA website at: http://www.cpha.ca

Abdallah S. Daar, Laureate of the Avicenna Prize for Ethics in Science 2005

For more information, please see the UNESCO website at: http://portal.unesco.org/shs/en/ev.php-URL_ID=7926&URL_DO=DO_TOPIC&URL_SECTION=201.html

Pop News Evaluation: How are We Doing?

As **Pop News** is now at the end of its second year of publication, the IPPH staff would like to know whether or not it is meeting your needs. After reading this issue, could you please assist in evaluating **Pop News** by clicking on the link below and answering the subsequent questions. Your feedback is much appreciated.

http://www.feedbackform.ca/

Recently Funded Initiatives

IPPH recently funded a number of projects in the areas of its strategic research priorities through the following competitions:

- Addressing Health Care and Health Policy Challenges of New Genetics Opportunities
- Research Syntheses: Priority Health Services and Systems
- Pilot Project Grants in Strategic Health Services and Policy Research Theme Areas
- Knowledge Translation Strategies for Health Research
- Excellence, Innovation and Advancement in the Study of Obesity and Healthy Body Weight - Operating and Pilot Project Grants in Childhood Obesity
- Fall 2004 Research Priority Announcements

For a complete list of projects that were funded under these initiatives, please consult our website at: http://www.cihr-irsc.gc.ca/e/26695.html

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CIHR IRSC

Upcoming IPPH Funding Opportunities
[Check the CIHR website in mid-June]

**Priority Announcement Competition -
Fellowships and Doctoral Research Awards**

Jointly issued by the CIHR-Institute of Population and Public Health (IPPH) and the Public Health Agency of Canada (PHAC), the purpose of this Priority Announcement is to strengthen public health research capacity thereby supporting the next generation of public health researchers, and stimulating public health policy- and practice-relevant research across the country.

Mental Health in the Workplace: Delivering Evidence for Action – Request for Applications

The purpose of this Request for Applications (RFA) is to support the creation of new or emerging teams of researchers undertaking action-oriented multidisciplinary research in collaboration with workplace stakeholders leading to improved mental health in the workplace. Teams are expected to undertake a program of research geared toward developing and testing policy and program interventions with regard to promotion, prevention, treatment, return to work, disability management, and/or stigma/discrimination in the workplace. Research must be relevant to workplaces and conducted in partnership with workplace partners from the public or private sectors. Partnerships at regional, provincial/territorial, and/or national levels with workplace stakeholders will ensure greater relevance of the research and increase the transfer and uptake of knowledge, ultimately leading to a healthier workplace, greater productivity and greater quality of life.

CIHR Website: http://www.cihr-irsc.gc.ca/

IPPH Publications

The following Publications are available in both print and electronic form. To download a .pdf or .html file of these documents, please visit our website at http://www.cihr-irsc.gc.ca/institutes/ipph/publications/index_e.shtml

**Mapping and Tapping the Wellsprings of Health,
Strategic Plan 2002-2007—Full Plan and Executive Summary**

Institute of Population and Public Health Annual Reports

Charting the Course Progress Report: Two Years Later: How Are We Doing?

Building Public Health Research, Education and Development in Canada: A Five-Site Consultation

Establishing a Long-term Agenda for Workplace Mental Health Research

The Future of Public Health in Canada: Developing a Public Health System for the 21st Century